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Population Services International

Social marketing Assessment For HIV / STI Prevention In the Central Asian Republics of Kazakhstan, Kyrgyzstan and Uzbekistan

Submitted to: USAID / Central Asia in Almaty, Kazakhstan

May 2001

SOCIAL MARKETING ASSESSMENT
For HIV/STI Prevention in the Central Asian Republics of
Kazakhstan, Kyrgyzstan and Uzbekistan
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EXECUTIVE SUMMARY

Population Services International (PSI) was contracted by USAID/CAR, through AIDSMark, to assess the need for and feasibility of social marketing for HIV and STI prevention in Kazakhstan, Kyrgyzstan and Uzbekistan.

Objectives:

- Review priority needs in the field of HIV/STI prevention;
- Survey current public and private sector programs to address these needs, and determine the capacity and interest of implementing organizations to contribute to a condom social marketing program;
- Assess the current volume, distribution, availability, and pricing of condoms, to the extent possible;
- Evaluate the potential of social marketing to fill gaps in current HIV/STI programming and, if favorable, determine what initial steps would be necessary to design and implement a social marketing program; and
- Conduct an informal review of the potential for social marketing to contribute to other reproductive health and primary healthcare needs.

General findings:

- HIV prevalence can be officially classified as low-level, but passive data surveillance systems are unlikely to reflect the true magnitude and profile of the problem;
- Incidence of registered STIs such as syphilis and gonorrhea is in decline, but the rate of unregistered cases–according to knowledgeable observers–has risen significantly;
- Populations most vulnerable to HIV and STIs such as injecting drug users (IDUs), commercial sex workers (CSWs), and vulnerable youth appear to be growing;
- Youth account for a significant share of the IDU and CSW populations;
- There are substantial numbers of men who have sex with men (MSM) in the capital cities of Kazakhstan and Kyrgyzstan, and these communities are increasingly open;
- The sharing of drugs and equipment among IDUs, and unprotected sex with multiple partners among all risk groups are said to be common;
- Sexual and reproductive health knowledge is weak, particularly among men and youth; age at first intercourse among men is widely thought to be 13-16
- Use of modern contraception, including condoms, is very low;
- Existing condom supply is insufficient to meet current demand.

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1 INTRODUCTION

USAID/Central Asia contracted Population Services International (PSI), through AIDSMark, to assess the need for and feasibility of a social marketing intervention for the prevention of HIV/AIDS and sexually transmitted infections (STIs) in Kazakhstan, Kyrgyzstan and Uzbekistan. The specific objectives of this assessment were to:

- Review priority needs in the field of HIV/STI prevention;
- Survey current public and private sector programs to address these needs, and determine the capacity and interest of implementing organizations to contribute to a social marketing program;
- Assess the current volume, distribution, availability, and pricing of condoms, to the extent possible;
- Evaluate the potential of social marketing to fill gaps in current HIV/STI programming and, if favorable, determine what initial steps would be necessary to design and implement a social marketing program; and
- Conduct an informal review of the potential for social marketing to contribute to other reproductive health and primary healthcare needs.

The assessment was conducted during March-April 2001. PSI's regional representative for CEE/NIS, Michael Holscher, and product specialist Richard Harrison spent almost four weeks in the three countries conducting interviews with key representatives of USAID, host government institutions, health providers, leading non-governmental organizations (NGOs), international donors and multilateral agencies, advertising agencies, television and radio outlets, market research firms, consumer product and pharmaceutical distribution companies, and pharmacists and commercial retailers. Mr. Holscher and Mr. Harrison toured cities, transportation hubs (e.g. train stations, truck stops), communities of internally displaced persons (IDP), needle exchange points, and other potentially high-risk environments for HIV/STI transmission, and talked informally with members of potential at-risk populations for HIV and STIs.

The purposes of this report are to: 1) summarize the activities and findings of the March-April 2001 assessment; 2) make recommendations to USAID/Central Asia concerning whether and how to proceed with a social marketing intervention; and 3) provide a preliminary action plan for any such intervention.

This report includes a summary of relevant data concerning the current HIV/STI situation in Kazakhstan, Kyrgyzstan and Uzbekistan. Since social marketing is primarily concerned with issues surrounding delivery of prevention information, products and services, the authors have not included detailed technical data related to HIV/STI diagnostics and surveillance.

2 BACKGROUND

The Central Asian Republics (CARs) of the former Soviet Union (FSU) are made up of five independent countries: Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan and Turkmenistan. Together, they comprise a region which is more than 2,000km wide at its widest point, by 1,200km on its North-South axis. The region known as Central Asia borders Russia to the west and to the north, China to the east, and Afghanistan and Iran to the south. Historically, the indigenous people who live in Central Asia belong to various divisions of Turkic tribes (Kazakhstan alone is represented by more than 100 nationalities), and have their earliest origins in about the 6th century AD. Although the region is often referred to as an integrated group of republics possessing much the same characteristics (indeed, all share Sunni Islam as their religions, and all have the same Soviet heritage), each country is distinguished by individual linguistic, cultural and socioeconomic nuances. In short, great care should be exercised when attempting to draw conclusions from generalizations concerning the countries that together make up Central Asia.

This assessment will focus on three of these countries: Kazakhstan, Kyrgyzstan and Uzbekistan. Of the three, Kazakhstan and Uzbekistan are by far the largest, both in terms of population size and GDP; by comparison, Kyrgyzstan is characterized by a small population and low levels of economic activity. All three countries have endured a painful socioeconomic transition over the past decade, and this is partly reflected in the declining health of the region's population.

Table 1: General Socioeconomic & Demographic Overview

	Kazakhstan	**Kyrgyzstan**	**Uzbekistan**
Language	Kazakh (Turkic) Russian	Kyrgyz (Turkic) Russian	Uzbek (Turkic) Russian
Population Size	14.9m (1999)	4.9m (2000)	24.8m (2000)
Urban Population	56% (1999)	34% (1997)	39% (1996)
Population Density	6 per sq km	N/a	47 per sq km
Demographic Change	0.5% per year	N/a	2.5% per year
Ethnic Breakdown	53% Kazakh 30% Russian 16.6% Ukrainian, Uzbek, German, Tartar, Korean (1999)	61% Kyrgyz 15% Russian 14% Uzbek 10% Ukrainian, German, Tartar, Dungar, Uigur, Korean (1997)	71% Uzbek 29% Russian, Tajik, Kazakh, Tartar (1996)
Religion	Sunni Islam	Sunni Islam	Sunni Islam
Economy	Large oil & gas reserves Gold and other metal mining Specialist machine making	Manufacturing and light industry (38% of economy) Agriculture (30% of economy)	Mainly agricultural (cotton). Gold mining.

Sources: PRB, Macro International[i]

All three countries have suffered huge socioeconomic upheavals since they gained independence from the Soviet Union in 1991, with rising unemployment and generally destabilized economies directly affecting poverty levels, mobility, prostitution and social attitudes towards sex and sexuality. Whilst these upheavals have affected almost all segments of society, young people have been hit particularly hard, with falling quality of schooling and general disillusionment adversely affecting behavior patterns and young

people's attitudes towards drugs and risky sexual behavior—all of which are leading risk factors for HIV and STIs. It is thought that in Central Asia young people (15-25) account for more than 70% of all IDUs.

The declining health of the region is further characterized by increasing rates of infant and perinatal mortality, cardiovascular disease, tuberculosis, respiratory diseases and cancer. There is also a clear picture that clearly shows dramatic increases in infectious diseases such as HIV/AIDS and STIs. Indeed, while HIV/AIDS rates are still cited by many field exports to be at relatively "low levels", the cumulative incidence of HIV infection as well as the exponential increase in other sexually transmitted infections suggest that the window of opportunity for early targeted interventions is rapidly closing. A key feature of HIV/AIDS in Central Asia (as in many other regions) is that the disease carries an extremely strong stigma, as evidenced by research that shows that 31% of women in Kazakhstan would not be willing to care for a relative with AIDS at home. This stigma has resulted in a large number of HIV/AIDS cases being kept "secret", therefore throwing into question the reliability of most data currently available.

Both official and unofficial data sources agree on at least one issue: the HIV infection rate in these three countries has seen a notable leap in the last three years, particularly among IDUs, which make up at least 64% of all HIV cases. As for STIs, according to a 1998 UNICEF/UNAIDS report, the incidence of syphilis has risen sharply in some of the countries of Central/Eastern Europe and the FSU, from 5-15 per 100,000 population in 1990 to 200-500 per 100,000 by 1996.[ii] The figures for 2000 are believed to reflect a continuation of this trend, although reliable data on infectious disease trends in Central Asia is scarce owing to poor screening and reporting systems. Nevertheless, dramatic increases in rates of STIs indicate a future potential for HIV to spread more rapidly among a wider population through sexual contact.

2.1 Social Marketing as a Behavior Change Strategy

An increasing number of CEE/NIS countries are turning to social marketing to address the need for more effective HIV/AIDS prevention.
Social marketing is the systematic use of commercial marketing strategies reinforced by interpersonal communication (IPC) to motivate targeted populations—especially lower-income or marginalized populations—to practice healthy behavior. Social marketing, as practiced by PSI, is a comprehensive behavior change methodology. It focuses on the end users and seeks to influence a set of inter-related influencing factors which include:

- Individual predisposition, such as knowledge, personal risk assessment, self efficacy, and risk perceptions;
- Social support, such as cultural traditions, peer influences, religious factors, gender differences, interaction between partners; and
- Material conditions, access to products, affordability of products.

PSI's behavior change framework (see Appendix iii) can be applied to any target group: IDUs, CSWs, MSM, IDP, mobile workers, prisoners, youth, etc. Implicit in the framework is an understanding that not all factors have the same weight for each target group. For example, a CSW may know about HIV/AIDS and understand her risk (individual predisposition), have easy access to condoms that she considers affordable (material conditions), but still not practice condom use because her clients or pimp strongly object to the behavior (social support). Conversely, a sexually-active adolescent girl with multiple partners may understand her HIV risk, enjoy the support of friends who think condoms are "cool", but still not practice condom use because she cannot find appealing condoms that she can purchase discreetly and at a price she can afford. Because each target group responds in a unique way to a particular set of influencing factors, social marketing begins by analyzing the specific barriers to healthy behavior for each target group. The diagram at Appendix (iii) represents a typical set of influencing factors in the context of AIDS prevention behaviors.

Social marketing strategies to overcome these key barriers to effective HIV/AIDS prevention typically include c*reative media and communications* to raise awareness and improve individual knowledge and risk perception among identified risk groups; *community mobilization and targeted peer outreach* to overcome environmental resistance and foster social support for risk reduction behaviors; and e*ffective distribution* of quality condoms to ensure that there is at least one condom option that is priced affordably and available when and where it is needed by identified risk groups. This integration of programmatic strategies to improve knowledge, address social and cultural resistance, and ensure product/service supply has made social marketing an effective tool for achieving behavior change objectives.

For example, PSI's comprehensive social marketing intervention in Romania used integrated media, peer outreach and condom distribution strategies to bring about a dramatic increase in condom use for HIV/AIDS prevention among its youth target audience. A national survey carried out in 1999 by Romania's Public Health and Health Management Association and the United States Centers for Disease Control and Prevention (CDC) discovered a 45% increase in condom use among sexually active unmarried young women (ages 15-24) during this period. Moreover, condom use at first premarital intercourse increased more than 100% for both men and women (aged 15-25) during the same three year period, when the social marketing intervention was Romania's only national HIV/STI prevention program.

As with commercial marketing, social marketing is an intensely client-oriented discipline. It uses extensive audience research to understand the needs of its target "clients", systematically involves these clients in the design and implementation of strategies to meet these needs, and continually monitors and evaluates progress towards doing so. However, unlike commercial marketing—which seeks to maximize profits—social marketing seeks to maximize *health benefits* even if no profit is achieved.[1]

[1]PSI social marketing interventions that include product sales give priority to ensuring that these products/services are affordable to those on the low end of a cash economy. This often means that the final

In fact, some social marketing interventions for HIV/AIDS prevention involve little, if any, condom distribution. If formative research with a particular target group finds that product-related barriers to healthy behavior are unimportant, or nonexistent, then social marketing resources are focused on knowledge and environmental barriers through IEC, community mobilization and peer outreach to risk groups.

Ultimately, social marketing works to exploit the dynamism, efficiency and strong client-orientation of the private sector to serve public health goals. It does so in cooperation with public, non-profit and commercial sector partners to harness the resources of all three for integrated health campaigns. In so doing, social marketing has the opportunity to improve local capacity—particularly in areas such as audience research, communications, client-based peer outreach, logistics and effective management–through formal and on-the-job training with local staff and partner organizations.

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consumer price is lower than the unit price initially paid by PSI to the manufacturer and results in a net financial loss on the overall product distribution activity. Nevertheless, selling (rather than free distribution) is considered important for three reasons: a) charging even a small price increases the chance that the product will be valued and, thus, used by the target user; b) selling enables social marketing programs to access commercial distribution networks, which are typically the most convenient and efficient; and c) sales revenues are reinvested in social marketing activities, reducing donor burdens over time.

3 FINDINGS FROM SITE VISITS, INTERVIEWS AND SECONDARY RESEARCH

Major gaps in data, and clear differences between official and unofficial reporting, make it an interesting challenge to evaluate the potential for social marketing in Kazakhstan, Kyrgyzstan and Uzbekistan. It should be noted that while existing data strongly suggests that the emerging HIV/AIDS trends (not absolute numbers) mirror those in neighboring countries in the Former Soviet Union (FSU), there are some clear differences in the way in which the three countries have approached the problem.

3.1 Situation of HIV, STIs and Vulnerable Groups

3.1.1 HIV/AIDS

Current HIV prevalence in all three countries can be classified as low-level, especially when compared to the very high numbers being recorded in neighboring Russia (some estimates put the figure at 80,000 for Russia). It can also be stated that there are signs of a steady increase in HIV/AIDS prevalence in all three countries, particularly amongst IDUs.

In Kazakhstan, according to the Ministry of Health Republican Center for AIDS Prevention and Control, the cumulative cases of HIV number 1,470, of which 374 (25% of the total) were recorded as "new cases" in 2000. In the first 3 months of 2001 a further 100 cases were recorded, suggesting a rising trend. However, it is likely that the real cumulative figure could be as much as 15 times higher (as many as 22,000) owing to poor reporting mechanisms and the fact that many cases are simply not made official. According to official Kazakh statistics, more than three-quarters (84%) of these reported cases were among Kazakhstan's 33,000 officially registered IDUs, while just 6% of CSWs are thought to be HIV positive. Around 75% of all cases are among males, and around 40% of all HIV cases are former prison inmates. The reported HIV infection rate among MSM is reported to be falling from already low levels.

In Kyrgyzstan, a total of 81 cases had been reported to the MOH's Ministry of Public Health Services as of March 2001, of which around 30 (37% of the total) have been recorded since mid-2000. Most of these cases appear to be in the southern part of Kyrgyzstan in the Osh (situated adjacent to the border with Uzbekistan and on the edge of the Ferghana valley), Naryn and Batken Oblasts, and more than 75% of the total cases were among foreign nationals. Indeed, Osh alone has recorded 23 official HIV cases (28% of the total number of cases in the country), although state officials suspect that the real number is closer to 200, mostly concentrated among young drug users.

In Kyrgyzstan as a whole, IDUs account for the majority of total reported cases (44%), closely followed by heterosexual contacts (43%).

In Uzbekistan, official data compiled at the end of 2000 puts the number of HIV cases at 230, of which 85 cases are in Tashkent, 80 cases are in Yangi-Yul, and just 5 cases in Ferghana Oblast. While official estimates are relatively low, the Ministry of Health admits that recent increases indicate that the infection rate is a serious cause for concern,

and that condoms and needles are needed in large quantities to keep the situation under control. According to WHO statistics, sexual transmission is responsible for 17% of total HIV cases in Uzbekistan. According to the Republican Dermatological and Venereology Institute, 86% of all officially reported HIV cases as of March 2001 were infected via syringes (i.e., among IDUs), compared to 80% in 1999 and 25% in 1998. The Tashkent Pediatric Hospital has just seen its first official case of vertical transmission in a newly born baby.

One of the weaknesses of official HIV/AIDS reporting in these three countries (as is the case elsewhere in the FSU), is that reporting systems probably fail to capture the true scope of the HIV/AIDS mini-epidemic in the region. Passive systems, and a reporting structure which, it is believed, forces many ill people to avoid visiting official clinics for fear of being included in official figures, belie an increasingly serious problem. In any case, the trends that are appearing in Central Asia generally match trends being recorded—via both official and unofficial statistics—in other FSU countries such as Ukraine, Georgia and Azerbaijan (i.e., transmission primarily through IDUs and heterosexual contact). It is also worth noting that social and cultural barriers in Kazakhstan, Kyrgyzstan and Uzbekistan probably make it difficult for HIV-infected (or simply at-risk people) even to acknowledge risky behavior such as IDU, sex work and homosexuality.

3.1.2 STIs

In all three countries, there is limited data concerning sexually transmitted diseases and infections. Almost all official data indicate that that incidence rates are falling, although this may be more as a result of the unwillingness of patients to approach official clinics and an increase in the number of patients self-treating.

Kazakhstan's population appears to have a relatively low level of awareness regarding STIs and their symptoms and relationship in terms of transmission to HIV/AIDS. The lack of surveillance or "case notification" data and poor data collection techniques mean that reliable data is not available. Anecdotal and physical evidence points to a growing STI problem in Kazakhstan, both in terms of the increasing number of STI cases among adults (many go unreported) and increasing number of congenital cases. Indeed, according to a UNAIDS representative the assessment team met with in Almaty, more than 1% of registered pregnant women are thought to be carrying syphilis in Kazakhstan.

In a 1996 survey 18% of women and 7% of men said that they had never heard of such infections. The survey also demonstrated that Kazakhs have a low level of understanding of STI symptoms, which raises concern because of their potential contribution to future epidemics of HIV/AIDS and other STIs[iii]. This worrying trend is exacerbated by the high number of men involved with risky sexual behavior: according to the same survey, around 10% of married Kazakh men report having extra-marital sexual relationships, and 22% of unmarried men reported having multiple sex partners. In addition, 81% of women and 42% of men reported not using a condom during the last sexual intercourse with a non cohabiting partner.

In Kyrgyzstan, official reports indicate that syphilis has been on the rise for at least ten years. Between 1990 and 1997, the syphilis rate rose by 77 times to around 155 per 100,000 people – or around 6,700 in absolute numbers (Bishkek, the capital, saw a 140-fold increase in the incidence rate). However, official reporting also indicates that since 1997 a dramatic fall in the number of syphilis cases has occurred. In 1999, some 4,642 cases were officially registered, and by August 2000 this number had fallen to 2,496 (or 51.6 per 100,000). More than 50% of all syphilis sufferers in Kyrgyzstan are in the 20-29 age bracket, and 56% of the total are unemployed people. Unofficial statistics in Kyrgyzstan suggest that the real situation is masked by ineffective reporting mechanisms, and that the incidence rate for syphilis and other STIs is in fact rising rapidly. This is underlined by the fact that the country is witnessing a rise in the number of babies born with congenital syphilis in the last few years (according to the Ministry of Public Health Services 78 congenital cases were recorded in 2000). Kyrgyzstan is also witnessing a steep rise in infertility, especially amongst young men (aged 16-25 years) who have previously had gonorrhea. According to the Family Medical and Social Support Association in Osh, there are a disproportionate number of such cases occurring within Osh city. Research conducted by Medecins Sans Frontieres (MSF) which shows that syphilis cases in Osh are at likely to be twice as high as official estimates. Data collected by MSF's Rainbow Center in Osh shows that the number of STI sufferers in Osh rose from 639 in 2000 to 1,021 in 2001.

There has been a move in Kyrgyzstan to promote free and anonymous testing of STI sufferers. Indeed, some of the statistics that have emerged from these clinics have been particularly interesting. According to one NGO linked to the MOH's Narcology Department, of all the people who are tested specifically for STI in the free, anonymous clinics, around 8% turned out positive, which does suggest a wider problem (it should be noted that the conclusions of this research are based on relatively small numbers of people in Bishkek).

To put the STI crisis in Kyrgyzstan in perspective: in terms of the general health picture in Kyrgyzstan, the most common problem is respiratory disease, followed by cardiac disease and, in third place STIs. However, if the statistics are broken down by age grouping an interesting pattern emerges, revealing STIs to be the single most common problem among young men aged between 20 and 29.

Uzbekistan has seen a sharp increase in the number of STI patients since 1997. Official data from 1999 shows that there were 37.6/100,000 syphilis cases in the Republic, down from 45.5/100,000 syphilis cases in 1998. This same data also shows that the number of people with gonorrhea rose slightly in the same period, from 27/100,000 cases in 1998 to 30.1/100,000 cases in 1999. However, informal interviews held with a number of local health officials suggest that these official numbers significantly underestimate the true number of people with STIs in Uzbekistan. Indeed, in a meeting with the Uzbek Republican Reproductive Health Center, we were informed that the incidence of STIs in the Ferghana Valley alone has increased by 20 times in the last 10 years. Although no non-state research into the STI situation in Uzbekistan has been conducted to date, Abt

Associates told PSI that their annual KAPB survey, to be implemented in May 2001, will include some specific questions on STIs.

According to the Republican Dermatological and Venerological Institute, of the total number of cases in Uzbekistan, some 35% are in rural areas, and 66% are among unemployed people. We were also informed that genital tract infections are having a serious impact on male fertility: male to female infertility is now 3 to 1, mostly as a result of pre-marital infections.

3.1.3 Injecting Drug Use

As in most other countries in the FSU, there is limited research available on the scale of the injecting drug use problem in Kazakhstan, Kyrgyzstan and Uzbekistan. However, there is certainly no dispute over the fact that the region is generally afflicted by a very large supply of drugs, mainly heroin, which come in at very low prices from nearby Afghanistan. Heroin travels from Afghanistan, through Tajikistan, into Kyrgyzstan and Kazakhstan before being smuggled into Russia and out to western Europe and beyond. The drug dealers are generally the smugglers themselves, who are often paid in kind (rather than in cash) and are seeking to generate some cash before continuing their onward journeys. Injecting behaviors for medical purposes broadly match trends throughout eastern Europe / FSU, where syringes are widely used for the administering of antibiotics, vitamins etc. There are no legal restrictions on selling needles in pharmacies.

Furthermore, there is some evidence to suggest that the sharing of drugs and equipment is fairly common in Central Asia. Motivations may include practical considerations such as the financial benefit of sharing drug costs, or the need for safe spaces to prepare and use drugs.

In Kazakhstan, there is very little official data relating to drug use, but unofficial statistics suggest that there are around 80,000 drug users, of whom about 70% are IDUs. One of the key problem areas identified by the Kazakh government is the Karaganda region, in the north, where huge layoffs from the massive steel-making facility (formerly one of the largest steel-making facilities in the world) at Temirtau—part of the economic rationalization currently underway in the entire region—have resulted in a very large number of unemployed men, many of whom have turned to drugs and alcohol. One estimate puts the total number of IDUs in Karaganda at 8,000. It is generally perceived that much of the HIV/AIDS problem in Kazakhstan originates in Karaganda (indeed, even the Kyrgyz Ministry of Health cited Karaganda as the origin of some of Kyrgyzstan's HIV/AIDS problem).

In Kyrgyzstan, the scale of drug abuse is reaching critical levels, with key "flashpoints" in Osh, Dzhalabad, Talas, Issyk Kul, Batken and Naryn. According to the Kyrgyz Ministry of Public Health Services, officially registered IDUs number 4,459 (80% of which are men), although the true figure is probably in the 40-50,000 range. Indeed, one western-funded NGO we approached estimated that there are 100,000 drug abusers in Kyrgyzstan, of which 22,000 were in Bishkek, 25,000 in Osh and 25,000 in the Chui Valley.

In Osh, a key transit zone for the passage of drugs, users are increasingly turning to heroin, a dose of which can now be bought for less than the price of a bottle of beer (a gram of heroin costs around 50 som, or $1). According to the Osh Oblast AIDS Center, of all IDUs in Osh, 7% are also CSWs.

According to anecdotal evidence and interviews with workers at a needle exchange point in Osh, about 45% of IDUs are Uzbek, 30% are Kyrgyz and a further 30% are Russian or foreigners – an interesting finding as this breakdown of IDU use by ethnicity almost exactly mirrors the country's demographic makeup, indicating that no single ethnic group is more inclined to drug use than another.

The average age of drug users in Kyrgyzstan appears to be falling. In research conducted by one NGO linked to the Ministry of Health's Narcology Department, some 70% of users are "young people". This research also showed that about 40% of addicts have families (raising the spectre of increased risk of vertical transmission).

In Uzbekistan, official data estimates that there are officially 12,000 drug users in the Republic, although unofficial estimates put the real figure at closer to 60,000. Official estimates show that around 5% of all drug users are based in the cities of Ferghana and Yangi-Yul, which have long been targeted by international aid agencies as key flashpoints in terms of drug abuse. Research conducted by UNDP in Uzbekistan shows that IDU behavior patterns are changing, and that 95% of drug users in Uzbekistan have switched from traditional "Khanka" (non-purified opium) to heroin use. Anecdotal evidence shows that a dose of heroin costs just 2500 sum ($6.50), and that these low prices largely explain the new trend in injecting drug use.

3.1.4 Commercial Sex Work

Up-to-date and reliable information on the prevalence of commercial sex work in Kazakhstan, Kyrgyzstan or Uzbekistan does not exist. This is partly due to the difficulty of collating data on the subjects involved—the environment is an extremely fluid and changeable one—but also partly due to a lack of resources and among those working in the field of harm reduction and humanitarian assistance. Nevertheless, it is almost universally acknowledged by the organizations that we interviewed that the problem has grown in recent years—particularly in the larger cities of Almaty, Bishkek and Tashkent. The upward trend in Tashkent has allegedly faltered slightly in the last year or so owing to the large number of foreign nationals leaving the country as a direct result of Uzbekistan's currency convertibility policy.

In all three countries, there are three "tiers" of CSWs. The first tier are the "street girls", generally poor, young girls from rural areas who charge relatively low prices (upwards of $0.50). The second tier is made up of the CSWs who work via adverts, telephone and in the lower class hotels; these CSWs are more expensive and charge around $ 20-50 for a session. The third tier of CSWs work primarily in the more expensive hotels frequented by foreigners; this last category of CSWs can charge upwards of $50-100 per session, and as high as $500.

A clear thread that ran through our interviews in the region was the concern that many CSWs—especially those who have moved from rural to urban areas—appear to have very low risk awareness. Many such girls do not consider themselves to be "sex workers", believing that they will only be engaged in sex work for a short period of time before finding more suitable employment. Women sex workers in all three countries range in age from 15-50. Clients of sex workers are thought to fit all demographic categories related to age, education and income levels. Few CSWs appear to use drugs. Few CSWs appear to use condoms consistently.

In Kazakhstan, sex workers can easily be found in well-known areas of the city. There is one main street (Sanai Street), near the city center, which is generally lined with CSWs most of the day and night, and where CSWs work fairly openly. Large numbers of drivers are seen stopping and negotiating with CSWs, although police intervention is not uncommon. CSWs can also be found in public parks, near the main train station, and in the few popular night clubs that exist in the city center. Some sex work takes place in specially rented accommodation and in saunas as well as through "escort" services managed by intermediaries or "pimps".

In Kyrgyzstan, the dynamics for sex work is very similar. The main towns all have main streets where sex workers gather, with other sex work taking place in hotels and saunas. According to MSF, which works with about 400 CSWs in Osh, CSWs range from 12 to 50 years of age; the mean age is 18. It is thought that less than 10% of CSWs are drug users in Osh.

The demographics for sex work in Uzbekistan are slightly different. Most of the CSWs in Tashkent are street workers (mainly from Tashkent or Samarkand), owing to the declining number of foreign men, as mentioned above. Many of the "higher class" CSWs have tried to take advantage of the burgeoning demand in the Middle East and have moved to Bahrain and the UAE, with small numbers travelling on a regular basis to and from Italy. According to Sabo, an NGO working specifically with CSWs in Tashkent, local Uzbeks are more at risk from STIs and HIV than the local Russian CSWs. This is because Uzbek CSWs in the first "tier" know little about risks and are less likely to use a condom than sex workers in higher "tiers", where there are a greater number of Russians.

According to a UNDP consultant in Tashkent, the CSWs in Tashkent are not regular users of condoms, and have extremely low awareness of the risks associated with unprotected sex.

3.1.5 Men Who Have Sex With Men

There is undoubtedly a large number of men who have sex with men (MSM) in all three countries, but this group is by far the most stigmatized, and least understood, risk group in all three countries. Social taboos concerning homosexuality have played a large part in marginalizing MSM. Most men in this group are forced to hide their sexual behavior out of fear of persecution and prosecution, making it difficult for them to obtain information on issues such as safe sex and HIV/AIDS. Homosexuality has historically been illegal in

all three countries, and homosexual acts remain a criminal offence in Uzbekistan. There is very little in the way of MSM advocacy in Kazakhstan or Kyrgyzstan, and none at all in Uzbekistan. However, there is evidence of a core group of activists who have managed to create some degree of awareness—often using independent financial resources—and in some cases have managed to develop materials, activities or rudimentary services targeting this important risk group.

In Kazakhstan, the size of the MSM community is unknown, but UNAIDS estimates the number in Almaty to be 8-10,000. It appears that the MSM community circulates around the five nightclubs in the capital. There is one bar, Spartacus, which is known as a "gay bar", and which attracts a wide range of people. When the assessment team visited the club, we were informed that around 25% of the club's clientele were homosexual. A certain amount of safe sex material is known to circulate through this bar, but there was no evidence of serious attempts to educate or provide free condoms. Other MSM activity is known to take place in public parks and saunas. In general, informants were of the opinion that the MSM community was relatively aware of the risks of HIV/AIDS, but that access to condoms and lubricants was the main barrier to safe sexual behavior.

In Kyrgyzstan, informants openly acknowledged the presence of MSM. Indeed, almost all the people interviewed by the team were aware of the presence of a "gay club", Oasis. Oasis is an officially-registered NGO run by a small group of MSM using their own funding to provide (high-quality) educational material and free condoms to members (the club has received short-term financing from one international agency, but now relies on event ticket sales for cash flow). The club has an overall membership of around 5,000, with about 500 members attending events on a regular basis. By Kyrgyz standards, it could be said that Oasis is a very progressive organization: the club has regular "gay" discos and even organizes transvestite shows in the local circus.

According to the Kyrgyz government, the MSM factor in the country's HIV/AIDS problem is "not significant" thanks to an increase in awareness and a reasonably high level of condom use and safe sex practices. Nevertheless, data from other countries show that without support and information (social support to behavior practice), this group can quickly become at risk.

In Uzbekistan, informants were highly reluctant to discuss male-to-male sexual behavior. The general situation appears to be that MSM behavior is by no means uncommon, but that few MSMs identify themselves as "homosexual". Many MSMs meet through intermediaries or friends, and are confined to conducting their male-to-male sexual lives "underground" and out of sight of their peers or elders. One informant stated that MSM activity was "highly secretive". The assessment team was unable to find any specific bars or clubs which catered specifically for MSM or lesbians, although we were told of the presence of a local NGO, Anti-AIDS, which does some educational work with MSM.

3.1.6 Adolescents and Young Adults

Young people aged 15-25yrs account for a significant proportion of the populations of Kazakhstan, Kyrgyzstan and Uzbekistan. There is emerging evidence to suggest that

these groups may be disproportionately affected by the risk factors which currently exacerbate the HIV/AIDS problem in the region. However, very little is known about knowledge, attitudes and practices within this group, and what is known is used primarily to produce small amounts youth-friendly information (colorful pamphlets, booklets) to help young people protect themselves against HIV and STIs. In general, the small scale of activities focusing on youth in the areas of STI, HIV/AIDS and IDU consist of awareness-raising activities, do not appear to involve youth in project design and do not seem to have coherent long-term strategies for motivating youth to choose healthy behavior patterns.

In schools, such information is rarely available, with few teachers willing (or able) to teach even the basics about healthy sexual behavior. Some attempts have been made by the Ministries of Education to train teachers, but the impact is still extremely low.

This generally low level of knowledge and awareness among young people in the region is compounded by an increase in risky behavior resulting from the general relaxation in the "moral code" in the region since the collapse of the FSU, both in terms of sexual behavior and a marked increase in the numbers of young people experimenting and using drugs. Sexual activity, abortion and prostitution are all increasing among young people. Many young males start their sexual lives at 14–16 years, and anecdotal discussions held with various health specialists throughout the region indicate that many young boys are "initiated" by older boys or father figures who take them to CSWs.

Low levels of awareness, and increasingly risky behavior in an increasingly depressed economic environment where prospects are thin and hardship is prevalent makes for a generally pessimistic outlook, especially in the light of WHO statistics which show that around half of HIV infections globally now occur among people under the age of 25, and STI rates are higher among adolescents than for any other age group.

In Kazakhstan, UNICEF is funding a project (Information and Research for Civic Education), which covers 10 schools, although this is still at the pilot stage. In terms of local involvement, the Almaty Oblast AIDS Center (active only in the Almaty Oblast) appears to be most active with young people. The Center conducts educational work, including condom donations, with about 20% of the 400,000 schoolchildren, other young people and prisoners in its jurisdiction, and reports that drug abuse and abortion are the key characteristics of the "youth problem" in Almaty Oblast.

Kyrgyzstan, meanwhile, recently implemented a "Healthy Lifestyles" curriculum for schoolchildren, including a cursory coverage of HIV/AIDS—however, the curriculum only lasts for 8 hours over the course of an entire school year.

A similar program was instituted in Uzbekistan, but this program has been hampered by the general reticence of teachers and parents to accept the concept of discussing sensitive issues with young people. Teachers have been known to refuse to teach sex education material in class, and peer outreach workers have in some cases found it difficult to gain access to young people for this same reason. This attitude seems to stand in stark

contrast to the contacts that the assessment team made with young people in Tashkent. In one set of interviews, the assessment team met with a group of boys aged 15-16 years. The findings suggest that they were well-versed in basic sexual and reproductive health issues, and were reasonably aware of the risk of catching HIV/AIDS and the benefits of using condoms. One thread that ran through the interviews was the fact that these boys felt that their parents were out of touch, and that they (the boys) in fact probably knew more about "sex" than their parents.

3.1.7 Other Risk Groups

Regional and international experience have shown that mobile workers, drug traders, and prisoners may be at acute risk for HIV/AIDS due to the potential for overlapping environmental risk factors such as IDU, sex work, and MSM in their communities. Central Asia is centrally located on the drug route, promoting transient workers, and resulting in greater potential for increases in HIV incidence. There is also a large prison population living in harsh conditions.

3.2 Public Sector Response

Site visits and interviews with representatives of MOH, WHO, Oblast and Republican AIDS Centers etc. reveal that:

- public resources in all republics are stretched beyond their limits;
- priorities in HIV and STI prevention are unclear, resulting in a crisis management approach rather than coherent long-term prevention strategies;
- public sector free-of-charge condom supply currently accounts for a large proportion of overall condom volume in all three countries, but is highly sporadic and largely destined to distribution points unlikely to reach those most vulnerable to HIV and STI transmission; in Kazakhstan, public sector condoms may be sub-standard;
- officials responsible for AIDS and STI policy in Kazakhstan, Kyrgyzstan and Uzbekistan are supportive of additional interventions, and to social marketing in particular;
- youth, IDUs and CSWs are priority target groups;
- in Uzbekistan, government considers contraceptive supply as "emergency issue" to be addressed by international community.

3.3 NGO Sector Response

The assessment set out also to determine which international implementing agencies and local organizations are working in HIV/STI prevention, and to examine the extent to which existing programs have succeeded in implementing evidence-based health interventions and how they have impacted key knowledge, psycho-social and market barriers to healthy behavior. We also sought to determine the capacity and interest of these organizations to contribute to a social marketing program.

In general, we ascertained the following:

- Existing HIV/STI interventions in all three republics have limited reach. Local organizations are knowledgeable and enthusiastic but lack the technical skills and long-term strategies necessary to have meaningful behavior change impact.
- There are several organizations involved in broad reproductive health activities. However, these organizations still have limited reach in both sexual and reproductive health education and product/service distribution, especially for those most at risk for HIV and STI transmission. Existing information and product/service delivery are oriented towards married couples.
- Few NGOs are specifically dedicated to HIV/AIDS prevention. Kyrgyzstan has a Rainbow Center and IDU Trust Point in Osh that are enthusiastic but which lack resources, technical skills and a coherent long-term strategy. Most NGOs mentioned the lack of adequate and steady supply of condoms as a constraint on their work
- Few NGOs systematically target the sexual and reproductive health needs of adolescents and young adults, who account for a large proportion of the population and are generally most open to behavior change.

- International actors such as Abt Associates, IPPF and MSF are doing laudable work in reproductive health and AIDS prevention. However, no international organization is making coordinated, sustained use of *mass media, peer outreach and widespread product/service distribution* to motivate sustained behavior change among those most at risk for HIV and STI transmission.
- Peer outreach in all three countries, while referred to, is not implemented effectively. "Outreach" is overly medicalized and neglects the need for systematic involvement of risk group members themselves in designing and implementing outreach strategies.

3.3.1 Key organizations in Kazakhstan:

International Planned Parenthood Foundation (IPPF local affiliate) – a small, voluntary-based NGO which was founded in Kazakhstan in 1996 with the assistance of UNFPA. The general objectives of IPPF are threefold. Firstly, to create a new family planning and reproductive health curriculum in postgraduate Medical Faculties. IPPF has had this program approved by the Ministries of Health in four countries (except Turkmenistan) and a network of trainers has been built up to address educational needs. Secondly, to start family planning associations in each of the five Central Asian countries. Thirdly, to implement a Family Life Education element to school curriculum, including "Seminars for Youth" and focus groups for young people. This program is funded by the Dutch government for 2001.

Abt Associates - a US company supporting work in reproductive healthcare work; preparing protocols for healthcare guidelines; providing logistical and financial support to organizations working with STIs and HIV/AIDS; general health-related research; media work. Abt Associates has been working with the UN to help provide condoms in various pilot projects in Kazakhstan.

Kazakh Medical-Pedagogical Association (KMPA) - an NGO based in Almaty with its origins in the City Human Reproduction Center, a reproductive health training and consultation center. KMPA itself, which has been a member of the IPPF since 1996, has 12 branches throughout Kazakhstan and is involved in a large range of reproductive health issues. KMPA has in the past been involved with Somarc's Red Apple program. KMPA also works in close association with its sister organization, the Central Asian Medical-Pedagogical Association, which focuses on the same sex education issues as KMPA, but on a regional basis.

3.3.2 Key organizations in Kyrgyzstan:

Osh Trust Point (Osh) - a needle exchange point servicing some 300 customers per week. The Trust Point has a team of 6, some of whom are ex IDUs and two of whom are current IDUs themselves.

Family Medical and Social Support Association (Osh) - an NGO focusing on social patronage and social support. FMSSA has 2 city-based centers and 7 regional centers where workers counsel people with a range of medical/social problems, and has also been

distributing condoms on behalf of UNFPA, although its last delivery was in 1999. FMSSA also works closely with students in youth hostels and universities.

Medecins Sans Frontieres - the French NGO is focusing on curative treatment for STIs (including educational seminars with doctors and dermatologists and the preparation of protocols), and preventative programs to help control STIs and HIV/AIDS in the Osh region. MSF has targeted youth in general in its campaigns, via its Rainbow Center (soon to become an independent NGO – see below), and more specifically CSWs and IDUs. MSF works with some 350 CSWs in the region.

Rainbow Center - founded in 1998, Rainbow promotes condom use to youth of 15-25 years of age. Rainbow also works with secondary schools, universities and organized youth groups. The Center also assists with STI advice, providing support in free consultations at local clinics. Rainbow is currently searching for funding in order to assume independence from MSF.

Social Change and Adaptation of People (SCAP) - SCAP works with IDU, and has links to the Ministry Narcology Department. SCAP focuses on education, drug use training programs, consultations and needle distribution.

Tais - this small NGO consists of 20 volunteers, most of whom are ex-CSWs, working with street-based CSWs. Tais provides condoms and advice on safe sexual practice.

Family Planning Alliance - this NGO works in the reproductive health arena, and provides consultation to about 200 people per day, many of whom are women seeking advice on family planning methods.

Soros - Soros has been operating in Kyrgyzstan since 1998, and currently has two main projects, one in Bishkek and the other in Osh. The bulk of Soros' health work is outreach work combined with syringe exchange and provision of IEC materials (including 10,000 copies of IDU brochures). About 70% of Soros funding for health is directed to the needle exchange program, although this will change once the planned methadone projects take off. Soros conducts some work in prisons, of which there are 11 countrywide.

3.3.3 Key organizations in Uzbekistan:

Engender Health - a small NGO previously called AVSC International, working closely with UNFPA reproductive health projects in Kashandarya and Sukhandarya.

Sabo - a very small NGO funded by Soros, working with CSWs on the streets of Tashkent. Sabo conducts most of its work through volunteers, and relies on outreach workers. Sabo is probably the one NGO in Uzbekistan which is closest to the CSW population, and has a good perspective on the levels of condom use and drug use amongst the people with whom they work.

Soros - The Soros Foundation is running or financing around 18 programs in Uzbekistan, including some in public health and harm reduction. Soros is working in

capacity building programs. Soros is planning to introduce a methadone pilot project as well as a program designed to support NGOs actively working with CSWs.

Abt Associates (Ferghana Valley) - Via USAID's ZdravPlus projects, Abt Associates is involved with developing legislation, providing resources to local clinics, assisting with service and quality provision, and health reform work.

We met with a few other small NGOs, including Trust, Saudat, Uzbekistan Reproductive Health and Healthy Woman, most of whom focus on training and education

3.4 Commercial Sector Capacity

3.4.1 Retailers

- Private sector in all three countries is nascent, but has potential. Existing distribution systems are largely passive and invest little in active marketing and promotion strategies.
- There is little data in all three countries concerning overall condom volume, but volume appears to be low. Most commercial condoms enter the region through black market dealers. In Kyrgyzstan, the legitimate commercial sector accounts for 2% of total condom supply. One widely available medium-priced brand, Innotex of France, sold only 115,000 pieces in Kazakhstan during 2000.
- There are numerous condom brands in the capital cities of all three countries, although fewer in areas outside capital cities. Few individual brands are widely available. Many are of questionable quality and origin. Quality products such as Durex and Lifestyles are too expensive for most consumers, especially those on the low end of the cash economy. Distribution of most brands is sporadic; no quality brand is widely available.
- Quality condoms are, with few exceptions, currently available only in pharmacies, making consumer purchase inconvenient and often indiscreet. Non-pharmaceutical points of sale – which number more than 15,000 in Kazakhstan excluding cafés and bars – should be used to expand condom availability.
- Laws in Uzbekistan restrict the distribution of condoms outside pharmacies, although this law is widely violated. There are no such restrictions in Kazakhstan or Kyrgyzstan.

TABLE: Average consumer prices for a representative sample of condom brands (based on three-packs) in Kazakhstan, Kyrgyzstan and Uzbekistan (in US$)

Exchange rates:
Kazakh Tenge/$ = 146.06
Kyrgyz Som/$= 49.28
Uzbek Sum/$= 351.78

	Kazakhstan			**Kyrgyz.**			**Uzbek.**		
	Brand	Price/Unit	Price ($)	Brand	Price/Unit	Price ($)	Brand	Price/Unit	Price ($)
Low	Romed (UN) Green Love	25 Tenge 60 Tenge	0.17 0.41	Rough Rider	10 Som	0.20	Green Love	25 Sum	0.07
Medium	Innotek Rough Rider	150 Tenge 150 Tenge	1.02 1.02	Innotek	60 Som	1.21	Innotek	135 Sum	0.38
High	Durex	250 Tenge	1.71	Durex	100 Som	2.02	Lifestyles	750 Sum	2.13

3.4.2 Media, Advertising, Audience Research and Promotion

- Mass media is a main source of information in all countries. A high percentage of households have access to TV and radio. Private stations such as ORT, Pyramida and independent stations in Uzbekistan are increasingly professional in their programming.
- Advertising in all countries is nascent, although Kazakhstan appears more advanced than Kyrgyzstan and Uzbekistan. International agencies such as McCann-Erickson are offering increasingly professional services including local production. Advertising rates are relatively low, particularly in Kyrgyzstan and Uzbekistan.
- There are a handful of research organizations in each country, but all appear to excessively academic in orientation. Experience in consumer research is limited. In Kazakhstan, capacity for market surveys (e.g. retail audits) is relatively developed.
- All advertising, media and research organizations interviewed expressed interest in supporting a social marketing project.
- Efforts to date to promote condoms on TV have had mixed results, partly because campaigns were sporadic and used insufficient audience research and community mobilization in design and pre-and-post-testing.

3.5 International Assistance and Related Activities : Donors/International Agencies

- UNFPA has played a major role in condom supply and reproductive health education. However, financial constraints and other factors will likely result in a reduced capacity to contribute towards HIV/STI prevention in the future. They are undertaking cost-recovery schemes in Kyrgyzstan.
- UNAIDS is highly active under strong leadership and has achieved much under difficult circumstances. Political and programmatic support from UNAIDS will be vital in the design and implementation of any HIV/STI social marketing intervention in CAR.
- Soros is supporting harm reduction programs in Kazakhstan and Kyrgyzstan, albeit at a low level.
- UNICEF is supporting healthy lifestyles programs in Kazakhstan, which incorporate AIDS prevention themes and activities.
- GTZ and KFW have been marginally involved in contraceptive supply in the past and have vague plans to continue in at least some CAR countries, but likely not until mid-2002.

3.6 Potential Constraints

- Complex tax and regulatory regimes in all three countries will be a constraint. Currency convertibility in Uzbekistan is an added difficulty, resulting in almost no incentive for commercial suppliers to address current demand.
- Cultural barriers to condom use are pronounced in CAR. However, many informants believed that a mass media campaign advertising condoms is possible, as long as it follows a "step-by-step" approach that includes consultations with public leaders (e.g. mahallahs in Uzbekistan).
- Informants in Kazakhstan and Kyrgyzstan seemed relatively open about key risk behaviors such as IDU, CSW, MSM and sexual behavior in general. Informants in Uzbekistan seemed less open.

4 RECOMMENDATIONS FOR USAID RESPONSE

There is need for, and reasonable feasibility of, implementing a social marketing project HIV and STI prevention. It is recommended that USAID/CAR support the development of a Central Asia Social Marketing Program (CASMAP) to do the following[2]:

4.1 Design and implement broad-scale interventions targeting IDUs and CSWs

All available data indicate that IDUs currently account for a high percentage of reported HIV/AIDS cases in Central Asia. Sharing of drugs and injecting equipment appears to be common. Most IDUs are young men who are sexually active, have multiple partners and are not using condoms. The double risk of infection through unsafe injecting practices and unsafe sex make IDUs a priority target audience for HIV/AIDS prevention in Central Asia. The number of IDUs who will be reached by existing or planned interventions is low. There is critical need for USAID to play a leadership role in improving both the quality and scale of IDU outreach in CAR.

Heterosexual contact accounts for the second greatest share of reported HIV/AIDS cases in the region. Sex workers with a high frequency of such contacts are especially vulnerable to HIV infection. The number of sex workers is believed to have increased significantly in recent years. Evidence suggests that many of these CSWs have anywhere from 5 to 25 partners per week, regularly engage in high risk sexual behaviors and do not use condoms. CSWs in some parts of CAR have a past history of STIs, indicating higher vulnerability to HIV/AIDS.

USAID's support for social marketing should give priority to broad scale interventions targeting IDUs and CSWs as the most at-risk groups. Particular attention should be given to areas in CAR where these risk populations overlap, such as the capital cities of Almaty, Bishkek and Tashkent, as well as Osh, Yangi Yul, and Kostanai. Furthermore, the apparent presence of injecting behaviors and sexual activity in prisons suggest that prisons would be an important target for USAID supported activities, although feasibility would appear greater in Kazakhstan and Kyrgyzstan than in Uzbekistan.

4.2 Implement wider risk reduction campaigns for vulnerable youth (aged 15-25).

Young people in CAR comprise a significant proportion of the total population in Central Asia. Available data suggest that these youth are especially vulnerable to the risk factors currently feeding the region's rising HIV/AIDS rates. Young people already account for a substantial share of known CSWs and IDUs. Many more young people are at risk for dropping out of school, unemployment, and conflicts with the law which can be closely related to IDU and CSW. Young men in urban areas are becoming sexually active at younger ages, and there are strong indications that many young boys begin their sexual

[2] The recommendations are prioritized, with the most important intervention listed first.

lives through experimentation with sex workers. This growing sexual interaction between vulnerable youth and other at-risk groups – IDUs and CSWs – makes young people a potential conduit of transmission for HIV and STIs from at-risk groups to the general population.

While little formal data exist, most informed observers -- including those currently working with youth -- acknowledge that young people in Central Asia have little specific information about HIV, STIs and related issues and have few resources available to learn more. Existing programs are overly-didactic in nature and have limited reach.

USAID should support social marketing strategies to reach vulnerable young people before high-risk habits are formed. This is important in order to begin the long term process of changing safer sex norms in the region as youth are most likely to adopt new behaviors and create new safer sex norms. Social marketing strategies could include the use of creative mass media campaigns to raise awareness about HIV/AIDS, improve knowledge about prevention, and create a climate more open and favorable to prevention. Mass media should be complemented with youth-to-youth outreach to improve knowledge and build peer group support for condom use and other preventive behaviors (e.g. avoiding drug use, monogamy, etc.). These activities could include events which combine education with entertainment such as concerts, sporting events, etc. Well-known bands, sport stars, and other role models can be enlisted to speak out on the need for HIV prevention, including participation in community mobilization efforts targeting key opinion leaders at the national and local levels.

The programmatic synergy between targeted interventions for immediately vulnerable risk groups and a wider risk reduction campaign for youth will allow USAID-supported activities to avoid reinforcing the marginalization of risk groups by raising awareness among a wider audience about HIV/AIDS risk factors and preventive behaviors.

4.3 Improve access to affordable condoms for risk groups through private commercial and non-profit channels

Experience throughout CEE/NIS has shown that even those who perceive themselves to be at risk for HIV and STIs will not always use condoms unless condom purchase is convenient, discreet and affordable. Although more data are needed to evaluate potential product-related barriers in Central Asia, available information suggests strongly that they do exist. There are several commercial condom brands in the region, but distribution is limited to pharmacies. Few brands appear to be available in more than a few pharmacies, and these are priced at a level that is likely too high for the targeted end-users to habitually afford. Public sector distribution is plagued by poor quality products, sporadic distribution, and the absence of effective targeting and promotion for HIV/AIDS prevention. There are few, if any, NGOs or public institutions with the capacity to ensure a steady supply of condoms to sufficient numbers of high-risk groups such as IDUs and CSWs.

USAID should support strategies to maximize the availability of at least one quality, affordably priced condom for the identified risk groups. Initially, the task of identifying such groups on a broad scale will be difficult. Therefore, the first objective of this activity should be to get the program's low-cost brand into all existing pharmaceutical outlets and non-pharmaceutical consumer product outlets such as bazaars, kiosks and mini-markets. Once sufficient mapping of risk groups has been carried out, priority should be to pioneer "non-traditional" distribution to areas and outlets convenient to these groups (e.g. meeting points for CSWs and their clients, gathering points for IDUs and "hang-out" locations for vulnerable youth). These would likely include bars, discos, public parks and transportation hubs. Distribution in prisons can also be explored.

To the extent possible, distribution strategies should experiment with opportunities for income-generation at the local level. PSI's international experience has shown that properly trained agents operating on a commission-only basis can be highly effective in opening-up new outlets for condoms within their communities.

4.4 Build capacity of local NGOs and community groups to respond to HIV/AIDS and STIs through training and involvement in social marketing

Existing local HIV/AIDS prevention efforts in Central Asia are committed and enthusiastic, but lack the specific technical skills and long-term strategies necessary to achieve real behavior change impact. IEC efforts consist mainly of traditional awareness-raising activities which fail to systematically address the environmental and material barriers that are often central to motivating behavior change – especially among the most vulnerable groups. Outreach activities are overly medicalized and neglect the critical need for the involvement of risk group members themselves in designing and implementing outreach strategies. The importance of audience research for project design and evaluation is not well understood.

USAID should support strategies to train and involve local NGOs and community groups in the design and implementation of social marketing activities for HIV/AIDS prevention. This would include training and participation in community mobilization, audience research, communications design and development, the use of mass media, peer outreach, product distribution/sales and general management. Doing so would allow the social marketing program to transfer the fundamental values of client-centered programming which is essential to public health interventions and yet foreign to organizations in many CEE/NIS countries. Ultimately, midterm and long-term capacity-building would contribute to a sustainable NGO-based social marketing model.

4.5 Pursue regional strategies for HIV/STI prevention in order to maximize health impact and cost-efficiency

The HIV/AIDS profiles among CAR countries are more alike than they are different. Prevalence in all countries can be classified as low-level and growing. Emerging trends suggest that priority risk groups are the same. All countries have large and growing populations of IDUs and significant mobility in some areas. Youth account for a significant proportion of the overall population and appear to be vulnerable to risky behaviors. Response to date has been limited.

Interestingly, while the situations are similar, the response capacity among the countries is not. USAID should take advantage of this by promoting heavy and systematic interaction among organizations in all countries to expand their capacity to carry-out social marketing activities. Given the unique values and skills required for effective social marketing, this capacity building can best be achieved by giving priority to capacity building for social marketing project staff in each country and then, through them, other local implementing partners. Staff and partners in CAR should also be linked with social marketing staff in Russia and other CEE/NIS countries.

Any such exchange activities would be most useful if they go beyond ephemeral conferences and seminars to give staff and partner organizations in each country practical reasons to work together. These may include cross-border activities (e.g. Ferghana Valley – Osh), sharing of materials for minority ethnic groups in each country (e.g. Uzbek minority in Kyrgyzstan) or joint condom orders and imports. Such activities will not only enhance the public health impact of HIV/AIDS activities, but will enable all countries to achieve cost-efficiencies in social marketing operations through the leveraging of human and financial resources.

5 PRELIMINARY PROGRAMMATIC CONSIDERATION

To assist USAID/CAR in determining how best to proceed with a social marketing program, this section offers programmatic suggestions for consideration in light of the findings above.

5.1 Priority Target Audiences

Available data would suggest the following primary and secondary target audiences for a Central Asia Social Marketing Program (CASMAP) would be:

Primary Target Audiences:
- IDUs
- CSWs
- Vulnerable Youth aged 15-25

Secondary Target Audiences
- National and community leaders
- Health professionals
- Local NGOs
- Mass media representatives
- Pharmacists and commercial retailers

5.2 Program Components

HIV/AIDS prevention behaviors are determined by a complex set of inter-related factors that fall into three main categories: individual predisposition, social support and material conditions. To address these factors in a comprehensive manner, the CASMAP should include the following five components:

Component A: Community Mobilization

Component B: Research, Evaluation and Monitoring

Component C: Peer Outreach and Media

Component D: Condom Accessibility

Component E: Capacity Building

To maximize program effectiveness and cost-efficiencies, these components should be integrated to the maximum extent possible. This can best be achieved through the use of a single implementing agency which would establish local social marketing management units in each country under the guidance of the agency's resident technical adviser(s). These core management units in each country would work with and through other organizations and community groups, when appropriate, to carry-out the following activities:

5.2.1 Community Mobilization

The purpose of this component would be to overcome potential social and cultural resistance to HIV/AIDS prevention programming, and to foster social support for healthy behavior among the identified target audiences. Community mobilization efforts would help to convince national and local community leaders (e.g. muhallahs) of the need to promote preventive behaviors, and to solicit their input for the development of the social marketing program.

Activities under this component would involve numerous presentations and events for key opinion leaders. The presentations would raise the visibility of the HIV/AIDS problem and cultivate support for more aggressive HIV prevention activities. The groups could include law enforcement agencies, health officials, religious leaders, community leaders, prison staff, school officials and parents. The presentations would summarize the results of audience research and highlight the specific needs of each identified target audience. Brief written summaries of the key facts about HIV and STIs can be prepared and distributed to local leaders and mass media representatives to ensure accurate understanding of the problem and proposed solutions.

To the extent possible, community mobilization activities should be carried out with other local organizations who share the program's goals and objectives. Peer leaders from the primary target audiences themselves can be involved in design and implementation. Ultimately community mobilization must maximize the prospect that local audiences will support – and not be shocked by – efforts to promote condoms and other preventive behaviors.

However, while it is essential to have the input of national and local leaders in the development of social marketing activities, this input can be destructive if its runs counter to obvious findings of audience research and regional/international best practices. Because social marketing has a bias towards the end-user, a key operational objective of any social marketing intervention is to strategically balance these considerations.

5.2.2 Research, Monitoring and Evaluation

CAR suffers from significant gaps in data that would be important to the design of effective social marketing activities. There are few data on the knowledge, attitudes and behaviors of the groups at highest risk for HIV/AIDS. Moreover, there is virtually no information on the group norms and social interactions which lead to high risk sexual behavior.

The social marketing program would seek to complement past and planned research in CAR by carrying-out research such as the following:

- qualitative formative research (focus groups and individual interviews) to explore group norms and social interactions and situations which lead to high risk sexual behaviors. Such research could also identify key resistance points and obstacles that work against the modification of current attitudes and behavioral patterns, and provide clues on how these resistance points and obstacles can be overcome through appropriate communications strategies. These resistance points may include: religious factors, lack of communication between sexual partners, family pressure, misinformation, fear of social isolation, incorrect or incomplete knowledge. Such information is critical to helping social marketing organizations to design communications activities.

- target group surveys to evaluate current knowledge, attitudes and behaviors of identified high-risk groups.

- condom availability, distribution and pricing surveys for the design of condom distribution strategies. This research will provide the project with baseline sales data.

- qualitative monitoring and evaluation methods (focus groups and one-on-one interviews) with randomly-selected representatives of selected target audiences to pre-test message and strategies before airing/implementation. The same messages will then be subject to periodic qualitative post-testing to assess their appropriateness and impact on the target audience. Based on such research, the social marketing program can continually adjust and improve its performance through systematic feedback from the target audiences.

Results from this research can, when appropriate, be published and widely distributed to public institutions, NGOs and international agencies working in HIV/STI prevention to assist them in improving existing and planned interventions. They can also be used in community mobilization activities to mobilize support for condom promotion and other HIV/STI activities.

5.2.3 Peer Outreach and Media

This program component would focus on addressing personal knowledge, risk assessment and peer/partner support barriers to HIV/AIDS prevention behavior. Using formative audience research, the program would design a strategic communications plan for each country. This plan would set forth a strategy for the coordinated use of peer outreach interventions and/or mass media to achieve behavior change in the identified target audiences. It would include a situational analysis for each target group and outline specific behavior change strategies for overcoming key barriers to healthy behavior. It would include details about the principal messages for each target audience and how these messages will be delivered. The plan would be developed with the active

involvement of target audiences themselves. Close consultations with NGO partners, public health officials and media representatives would assure the cultural appropriateness, feasibility and effectiveness of the planned responses. Finally, the plan would set forth a specific timetable for the implementation and evaluation of these activities.

While exact outreach and media activities can only be determined following formative research, likely activities would include:

Peer Outreach:

Peer outreach activities would involve members of each of the identified target groups in the design and development of innovative approaches to open-up discussion about HIV/AIDS and related issues. These activities would mix education with entertainment to help target groups more easily deal with the difficult subject matter. Peer leaders from within each group will be enlisted to facilitate these activities and to deliver the program's information and key messages.

Peer outreach activities for IDUs might include safer sex skits in which IDU group members act out familiar social or sexual situations. Such role-playing is a non-threatening and often humorous way to initiate discussions about key issues surrounding injecting behaviors and unsafe sex. Peer leaders can facilitate this role-playing, as well as distribute IDU-targeted IEC materials and condoms.

Peer outreach activities for sex workers could include a roving "Safer Sex Machine" which carries peer educators to areas known to be frequented by CSWs. These educators would talk with small groups of CSWs and distribute CSW-targeted HIV/STI prevention and condom promotion materials. The distribution of condoms could be combined with other products useful to CSWs (e.g. perfumes, make-up) in order to destigmatize condoms and condom use. "Miss Condom" mini-pageants can be held among CSWs in which the winner is chosen not just for physical appearance but also because of her knowledge about HIV/AIDS and condom use.

Peer outreach activities for vulnerable youth would involve higher-profile activities such as rock concerts, extreme sports competitions, street parties and other more public events. CAR countries have well-known young musicians and sports stars who could be enlisted to talk about HIV/AIDS prevention and related risk factors. Better-known stars from neighboring Russia could also be enlisted, if feasible. Extremely marginalized youth (street children) would be reached by targeting them in the places they are known to frequent. In every case, trained peer educators would be used to open-up discussions with young people, distribute program materials, organize events, and provide entertainment.

The success of these peer outreach efforts will depend heavily on the systematic involvement of risk group members at all levels of design, implementation and evaluation. The program will need to give priority to identifying and training target group

leaders who can gain access to these groups and help to build the program's networks over time. Building trust and protecting the confidentiality of these networks is essential.

Media

Mass media is a leading source of information in CAR countries, and may have a role to play in the social marketing program's communications strategy. For example, mass media could be used to carry out a risk reduction campaign for young people. This campaign would design and deliver youth-oriented messages about HIV/AIDS, condom use and drug prevention. These messages could be delivered via TV and radio in the form of advertising, talk shows, call-in programs, interviews, news stories and even youth-oriented game shows and mini-dramas. Multiple risk reduction messages (e.g. "use a condom", "no to drugs") could be integrated under a single umbrella theme if such integrated messages are found to be effective by research conducted. Electronic media can be reinforced with print media such as posters and booklets that answer the most common questions about these issues in a straightforward, non-technical manner. Outdoor advertising can also be used in strategic locations to get out the program's risk reduction message.

The project would need to pursue an aggressive public relations strategy to maximize free media coverage of the campaigns. This will involve forming open and effective relationships with representatives of the media, educating them on HIV/AIDS issues, and providing journalists with regular information on these issues to encourage favorable coverage. Given the sensitivities surrounding HIV/AIDS prevention, rapid response protocols will be established to correct misinformation and respond to public information that runs counter to the goals of the social marketing program.

5.2.4 Condom Accessibility

This component would focus on overcoming condom-related barriers to healthy behavior by working to ensure the steady supply of at least one appealing, affordable condom in outlets convenient to the identified risk groups. Using baseline condom availability, pricing and distribution data, the program would choose a condom brand, pricing structures and distribution strategies to meet the requirements of the targeted groups.

Since the identification and "mapping" of high-risk groups is likely to be difficult in the beginning, the program's first aim would be to get its low-cost brand into existing pharmaceutical and non-pharmaceutical outlets for condoms. Once sufficient information is known concerning social patterns of the identified risk groups, the program would set-out to pioneer "non-traditional" distribution to areas known to be frequented by these groups, such as meeting points for CSWs and their clients, gathering points for IDUs, and "hang-out" locations for out-of-school youth. Such places might include bars, discos, billiard halls, public parks, and transportation hubs. Distribution in prisons and can also be explored.

To the extent possible, these distribution efforts will work through existing commercial distribution networks. However, it is likely that the program will have to complement

these limited networks with its own direct distribution force and the creation of new NGO and micro-enterprise units for product distribution. PSI's international experience has shown that a modest commission and adequate training is sufficient motivation for community organizations and individuals to dramatically expand distribution in their communities.

To support these distribution efforts, the program would develop branded promotional materials for use in creating retail demand for the condom. These materials would include point-of-sales stickers and educational brochures, promotional posters, and displays to help the retailer stock and promote the product. Such materials can help considerably to convincing retailers to sell condoms. They also help consumers by informing them of condom availability by assisting them in overcoming the embarrassment of asking of condoms. These promotional activities should, to the maximum extent possible, be integrated with the planned IEC activities described above.

It is anticipated that promotion of the social marketed brand will lead to a universal increase in condom availability and sales. IEC activities carried out under Component B above will almost certainly increase demand for condoms other than the project's social marketed brand. Indeed, global social marketing experience has revealed a so-called "halo-effect" that increases sales of all condom brands, not just the social marketed brand.

The project condoms would not require funding or a subsidy from USAID. Other donors, such as the UK's Department for International Development (DFID), have expressed some interest in supporting commodity-related costs.

5.2.5 Capacity Building

To increase understanding about social marketing, and facilitate the transfer of social marketing know-how, core social marketing activities would be integrated with related training activities to build the capacity of program staff and local partner organizations. This would include training in basic social marketing principles (e.g. client-centered programming, peer outreach) as well as more technical knowledge and skills training in areas such as target audience research, harm reduction, peer outreach, media design and development, condom distribution, and organizational management. It could also include the dissemination of written materials such as practical guidelines for peer outreach and harm reduction.

The social marketing program would identify and recruit participants from interested organizations to take part in the training. It would then conduct an informal needs assessment to target training activities to the specific needs and skill levels of participants. Based on the needs assessment, the program would develop detailed training modules and comprehensive written materials, including information concerning regional and international best practices. For more technical training, local staff may need short-term technical assistance.

Training activities could also be integrated with community mobilization to transfer skills at the community level. This would allow the program to go beyond merely sensitizing local leaders to the HIV/AIDS problem to actually empowering them with knowledge and skills necessary to contribute to the program's development. Such activities may include sensitivity training with regard to high-risk groups and training in the principles of harm reduction to prison officials, leaders in IDP communities, and managers of high-mobility zones areas such as harbors, border crossings and truck inspection sites.

Finally, activities under this component would also include training for the program's condom distribution agents. These would include training for the program's own limited distribution force, the agents of commercial distribution partners, and NGOs and community-level micro-enterprises interested in becoming involved in condom distribution activities in targeted zones unreached by current distribution networks.

5.3 Management Issues

5.3.1 International Technical and Management Support

Existing human, physical, technical and financial resources are insufficient throughout CAR to support an effective social marketing program. Therefore, an experienced international social marketing organization is needed to provide the technical and managerial support necessary to carry out social marketing activities in the region.

Given the relatively recent development of the private sector in CAR countries, it is unlikely that any social marketing implementing agency would be able to identify a local national with the unique blend of knowledge and abilities necessary to design and manage an effective social marketing program. These include marketing, audience research, media design and development, events management, commodities procurement and distribution, advocacy and community mobilization, peer outreach, personnel management and development, and MIS design. Nevertheless, the implementing agency – through its resident adviser – will need to ensure that the social marketing program provides for the systematic transfer of knowledge and skills in these areas to local project staff and partner organizations over the long-term. However, for the short term, a fulltime expatriate resident advisor (RA) will be necessary to assume responsibility for management of the social marketing program.

Experience elsewhere in CEE/NIS suggests than an RA with the appropriate background and skills can best add value to a social marketing program by systematically representing regional and international best practices in the collaborative design and implementation of social marketing activities, by identifying and recruiting quality local resources, and by catalyzing cooperation among the public, commercial and non-profit sectors.

A RA would be responsible for the overall planning, development and implementation of program activities. S/he would handle the legal and regulatory issues involved in

launching the social marketing project, open an office, recruit project staff and partner organizations. S/he would manage the day-to-day affairs of the project, providing guidance to local staff and partners, and ensuring programmatic and financial excellence and oversight. The resident advisor would work to identify and recruit short-term technical support for the program's training, research, communications and financial control needs.

In addition, the RA would serve as the principal liaison to USAID, host government institutions, local and international NGOs, and key international organizations such as UNAIDS, UNICEF, and UNFPA. These relationships will be critical to the ongoing success of social marketing activities.

5.3.2 Local project staffing

An effective social marketing program in CAR will require sufficient local staffing in each country to efficiently implement the full range of proposed activities. While precise staffing will depend on final objectives and work plans, a core staff will likely require the following:

Marketing and Communication Manager – a senior local national with experience in project management, media, marketing and/or communications to manage the design, implementation and evaluation of all project research, communications, outreach and distribution activities

Marketing and Research Assistant – a junior local national with experience in research, training, and/or marketing to provide logistical and administrative support in the areas of community mobilization, research, training, communications and outreach activities.

Peer Outreach Coordinators – members of the identified target populations with easy access to their peers (e.g. IDUs, CSWs) and natural communications abilities, basic organizational skills, and a willingness to learn. Their roles would include designing, implementing and evaluating peer outreach interventions, and assisting with audience research and community mobilization.

Sales/Promotion Agents – junior local nationals with experience or interest in private sector distribution or sales to create a region-wide distribution network for the project's social marketed condom brand, and provide on-site training and guidance to import/distribution partners, pharmacists and shopkeepers concerning the proper storage and display of condoms, and basic education on the health benefits and proper use of condoms.

Financial/Administration Manager -- a senior certified public accountant to manage all aspects of financial management, including cash flow management, disbursement of funds, monitoring of budgets, establishing and maintaining financial control systems, financial reporting and MIS operations.

Administrative Assistant – a skilled local national to provide general administrative, logistical and linguistic support to the project

5.3.3 Management Information Systems (MIS)

Ongoing monitoring would be essential to measuring achievement of the project's purposes and outputs through evaluation research and reporting systems. Central to monitoring and evaluation of social marketing activities would be a management information system (MIS) to track project activities, provide direction for key management decisions, and improve cost-efficiencies. Project staff and partner organizations will be responsible for recording information on community mobilization, training, IEC and product distribution. This information will be submitted monthly for MIS input on an ongoing basis.

6 FUTURE POTENTIAL

Organizations like PSI are using social marketing to address a wide range of primary healthcare issues. These include social marketing programs to increase the use of modern contraception for family planning, to prevent malaria and diarrheal disease, to address nutritional deficiencies such as anemia and iodine deficiency among mothers and young children, to improve reproductive health service delivery, and to improve voluntary testing and counseling services for HIV/AIDS.

Primary healthcare needs in CAR are immense. Available information would suggest that CAR would benefit from additional social marketing interventions in many of the areas described above. USAID/CAR should consider phasing in additional products and health issues (e.g. hormonals, iodized salt, clean water systems, ORS, etc.) over the mid-term to expand impact and improve sustainability of social marketing in CAR.

Endnotes

[i] Kazakhstan Demographic and Health Survey, Macro International, National Institute of Nutrition and Academy of Preventative Medicine, November 1996.
Kyrgyz Republic Demographic and Health Survey, Macro International and Research Institute of Obstetrics and Pediatrics Macro International, August 1998.
Uzbekistan Demographic and Health Survey, Macro International, Institute of Obstetrics and Gaenacology (Ministry of Health), September 1997

[ii] Report on the First Meeting of the Task Force for the Urgent Response to the Epidemics of Sexually-Transmitted Diseases in Eastern Europe and Central Asia, UNICEF and UNAIDS, 23-24 February 1998.

[iii] Kazakhstan Demographic and Health Survey, Macro International, National Institute of Nutrition and Academy of Preventative Medicine, November 1996.

APPENDICES

Appendix i. Scope of Work for CAR Assessment

Purpose
To determine the need for and feasibility of a condom social marketing project for HIV/STI prevention in the Central Asian Republics of Kazakhstan, Kyrgyzstan and Uzbekistan.

Objectives

- The specific objectives of the assessment are to:
- Review priority needs in the field of HIV/STI prevention;
- Survey current public and private sector programs to address these needs, and determine the capacity and interest of implementing organizations to contribute to a condom social marketing program;
- Assess the current volume, distribution, availability, and pricing of condoms, to the extent possible;
- Evaluate the potential of social marketing to fill gaps in current HIV/STI programming and, if favorable, determine what initial steps would be necessary to design and implement a social marketing program;
- Conduct an informal review of the potential for social marketing to contribute to other reproductive health and primary healthcare needs.

III. Scope of Assessment

PSI will appoint its regional representative for CEE/NIS to review existing secondary research, if any, related to HIV/STI prevention in Kazakhstan, Kyrgyzstan and Uzbekistan. In addition, an assessment trip to Kazakhstan, Kyrgyzstan and Uzbekistan will be conducted during March-April 2001 to undertake activities in the following areas:

USAID

Meet with USAID staff to understand their needs, priorities and plans in HIV/STI prevention. Review relevant documents provided by the Mission. Identify other donors/agencies/NGOs who are involved in funding/implementing HIV/STI programs. Assess to what extent there is interest in a social marketing program.

Governments

Meet with Host Government person(s) responsible for AIDS/STI prevention. Determine Governments' national HIV/STI priorities. Analyze current resource allocation for HIV/STI programs. Find out which foreign assistance (bilateral, multilateral, NGO, other) is being provided or is in the pipeline. Review existing public sector interventions and capabilities. Get details on these programs, collect relevant documents, and present

social marketing principles and methodologies. Understand Governments' attitude towards using the private sector to achieve preventive care goals. Solicit their views on the prospects of social marketing to contribute towards achieving public health goals.

Review AIDS/STI situation in the countries. Using best available data, attempt to gather information concerning number of cases of HIV and other STIs. Determine whether HIV/STIs are viewed as a problem, and what the Governments have done or are planning to do to address them. Look into what structures have been set up, if any, for HIV/STI prevention and collect planning documents. Investigate whether Governments have, or plan to, establish a National AIDS Committee. Review recent technical assistance projects undertaken towards this goal. Review key implementing agencies and donors involved in HIV/STI prevention, evaluate their programs. Assess opportunities and constraints to condom promotion in general and condom social marketing in particular. Collect samples of public sector communication/education materials and evaluate these materials from a commercial marketing perspective, particularly the extent to which they are based on legitimate audience research.

Meet multilateral agencies such as UNICEF, UNFPA, WHO, etc. to solicit their input on the above-mentioned issues.

Commercial Sector

Attempt to assess capabilities of the private commercial sector involved in consumer and pharmaceutical product distribution and promotion.

Distribution

Meet with senior representatives of consumer product and pharmaceutical distribution companies. Attempt to determine supply, volume, pricing, coverage and brand names of condoms currently distributed by these companies. Try to determine market shares for key products. Review logistics systems to determine number of sales people and detail personnel, kinds of outlets, credit vs. cash sales, pricing structures, margins applied, geographic reach (rural vs. urban), MIS systems, import and warehousing arrangements, etc. Evaluate promotion activities, if any. Assess interest and capacity of commercial distribution companies to participate in condom social marketing program.

Retailers

Visit several consumer goods and pharmaceutical outlets. Purchase leading brands of condoms. Review packaging and placement of these condom products. Informally interview salespersons to determine source of supply, pricing structures, stock and inventory procedures, sales volumes, etc. Informally evaluate retailer perceptions of consumer purchasing habits and motivation for purchasing condoms (e.g. price, brand name, etc.). Attempt to generate profile of who generally buys various products (e.g. men or women, old or young). Informally evaluate knowledge and attitude of retailers towards condoms. Review existing point-of-purchase materials (i.e. stickers, counter-

displays, flyers, etc.) for condoms or HIV/STI prevention. Informally assess needs of retailers and their capacity to support a social marketing program.

Research and Promotion Companies

Determine who, if anyone, does consumer product market research and promotion. Identify any research conducted for condoms or health/pharmaceutical products/services in general. Meet with senior representatives of market research firms, ad agencies, local consumer product companies, universities, NGOs, government education units, private or government TV and radio stations that might have done market research. Collect copies of studies. Evaluate potential and interest of existing agencies to support research needs of social marketing program.

Conduct a review of local companies with experience in mass media production (TV, radio, press), and the production of packaging, point-of-purchase, and promotional items similar to that normally used in a social marketing project (T-shirts, coasters, key chains, etc.). Review the quality and costs of these services. Assess the potential and interest of existing companies to support media needs of social marketing program.

NGO Sector

Determine what international implementing agencies and local organizations are doing in HIV/STI prevention. Meet a few of the key groups. Examine the potential of existing programs to design and implement evidence-based health interventions and overcome key knowledge, psycho-social and market barriers to healthy behavior. Determine the capacity and interest of these organizations to contribute to a social marketing program.

General Issues/Constraints

Examine potential religious, literacy, multiple languages, political, human resource capability, or other cultural constraints. Inquire about contraceptive import tariffs and taxes on revenues for non-profit organizations. Investigate policies and laws, if any, which govern condom promotion/distribution and nonprofits. For example, where can condoms be sold (only in pharmacies, anywhere)? Investigate restrictions on promotion of condoms through mass media (TV, radio). Assess the ability of the communications infrastructure. Collect information on the reach and effectiveness of all forms of communication.

Presentation Workshop

Organize and facilitate a two (2) day planning workshop for 15-20 key stakeholders from Kazakhstan, Kyrgyzstan and Uzbekistan. Brief stakeholders on the preliminary findings of the field work and solicit their ideas for the development of a potential social marketing program in the Central Asian Republics. Provide a multimedia overview of social marketing and practical case studies from elsewhere in CEE/NIS.

Outputs

A trip report which:

- Summarizes the activities and findings outlined herein;
- Recommends for or against start-up activities for a social marketing program; and
- Provides a preliminary action plan in the event a positive recommendation for social marketing is made.

Appendix ii. Illustrative LogFrame (2001-2003)

NARRATIVE	INDICATORS (to be achieved by 2004)	VERIFICATION	ASSUMPTIONS
Goal To contribute to a reduction in HIV and STI transmission in Kazakhstan, Kyrgyzstan and Uzbekistan.	1. Decrease in HIV incidence among target populations 2. Decrease in STI incidence among target populations 3. Increase in reported condom use among target populations.	1-2 Sentinel surveillance (if available) 3. MOH 4 Project KAP	Integrated HIV and STI health activities implemented.
Purpose To increase behaviors conducive to sexual health and other risk reduction for HIV/AIDS and STI prevention in Kazakhstan, Kyrgyzstan, and Uzbekistan.	1. Increased % of target group reporting they use condoms "often" or "always." 2. Increased % of target group who used a condom during last sex act. 3. Decreased % of target group reporting multiple partners in the past 12 months. 4. Decreased % of 15-20 year olds who begin using injection drugs. 5. Number of project condoms sold by final year of project.	1-4 Project KAP 5 Project Sales Records	Social marketing condom sales complement existing commercial and public sector distribution. USAID provides sufficient financial support for social marketing beyond Y1-2. Local administrative and bureaucratic requirements do not overly constrain project.
Outputs 1. Increased access to quality, affordable condoms.	% of traditional outlets carrying SM condom brand Number of non-traditional outlets carry SM brand. % of target populations recalling SM brand % of target populations recalling at least one outlet where SM brand can be purchased % of target populations who consider SM brand affordable.	Project Retail Audits and Distribution Surveys Project Sales Records	SM project can successfully advocate for exception to, or removal of, legal and regulatory provisions restricting distribution and sales of condoms.
2. Increased knowledge and attitudes conducive to risk-reduction in youth	Increased % of people aged 15-24 who believes that HIV infection can be asymptomatic. Increased % of people aged 15-24 who agrees that multiple partners increases risk of HIV/STI infection. Increased % of respondents who know that injecting drug use is associated with increased HIV/STI risk. Increased % in people aged 15-24 who believes their partner would not object to condom use. % of people 15-24 who recognize SM condom brand or recalls most recent slogan/message. 100,000 people aged 15-24 reached through youth outreach activities.	Project KAP And Media Impact Studies (2)	Authorities approve new product registrations in a timely way. Concessionary rates are provided for public service advertising by mass media outlets.
3. Increased knowledge and attitudes conducive to risk and harm reduction for IDU	Increased % of respondents who do not share drug-related paraphernalia or who clean their drug equipment effectively. Increased % who are able to cite at least 2 accurate ways for reducing risk of HIV infection. Increased % of respondents able to accurately assess personal risk for HIV Increased % of those who state that sharing needles increases the likelihood of HIV/AIDS.	IDU Target Research	USAID permits social marketing project to disseminate IEC materials for high-risk groups (IDUs, CSWs, MSM) and to implement harm reduction activities.

Outputs (continued) 4. Increased knowledge and attitudes conducive to risk reduction in CSWs 5. Increased knowledge and attitudes conducive to risk reduction in MSM 6. Improved local capacity to implement HIV and STI prevention interventions. 7. Inter-country regional cooperation achieved.	Increased % who report condom use during last sex act with paying client. Increased % of those able to accurately assess personal risk of HIV. Increase in outlets frequented by CSWs that sell SM condom brand. Increased % of respondents reporting condom use in last sex act with a male partner. Increased % of respondents carrying condoms with them. Increased % of outlets frequented by MSM that sell SM condom brand. USAID/CAR staff receive training in social marketing. Ongoing formal and informal skills transfer to local social marketing staff, NGO partners, commercial sub-contractors and other stakeholders.(see 3) Community-mobilization activities carried out in targeted areas to sensitize local leaders and enlist their support. IEC materials, condoms, and appropriate research results widely disseminated to other organizations. Significant awareness of CAR project activities and risk reduction messages demonstrated. Management review conducted to evaluate social marketing project's organizational development, including its relationships with local partner organizations. CAR regional strategies developed for condom distribution and cross-border media and peer outreach, etc. Exchange visits carried out between CAR social marketing staff and professional staff from more established programs in Russia, Georgia and other CEE/NIS countries.	CSW Target Research MSM Target Research Quarterly Reports Training Participants evaluations MIS reports on sales, activities and dissemination of materials. PRISSM results report. Quarterly reports.	Social marketing project gets support from authorities in Kazakhstan, Kyrgyzstan and Uzbekistan for activities targeting high-risk groups. Social marketing activities complement existing and planned activities supported by USAID and other donors in the fields of HIV/AIDS and STI prevention and reproductive health.
<u>Target Populations:</u> 1. Primary Audience: Young People Aged 15-24 2. Secondary Audiences*: IDUs, CSWs, MSM	Levers: Strategic mass media, youth-to-youth outreach (edu-tainment), and condom distribution Levers: Peer-designed IEC and peer outreach, condom distribution		

(1) Emphasis will be given to geographic locations where risk behaviors are known or likely to be prevalent or overlapping (e.g. Almaty, Karaganda (Temirtau), Tashkent, the Ferghana Valley, Osh and Biskek), as well as other targeted locations such as military bases, prisons, and the dormitories of students and migrant workers.

(2) Social marketing research in CAR will complement other existing or planned research, and will be heavily weighted towards the needs, wants and desires of key target groups.

(3) Emphasis will be given to both national and local/regional leaders – formal and informal.

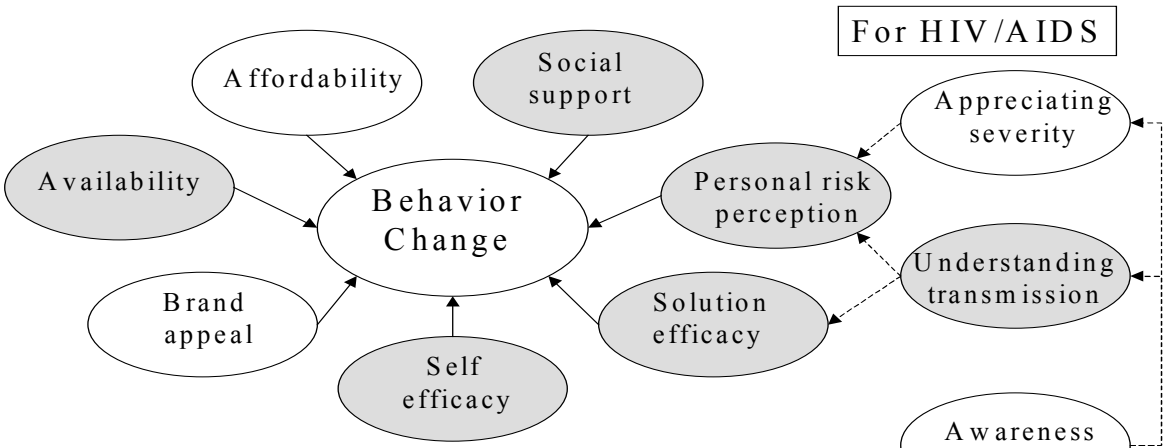
Appendix iii. Behavior Change Framework

The use of generic communications campaigns to complement brand marketing will increase the impact of this program. This is due to the fact that generic and branded strategies are complementary and can be used to address different types of behavioral issues.

Branded advertising campaigns generally attempt to establish positive relationships between the product and potential consumers. To do so, they will use a variety of positive messages, either explicit or implicit, and will influence the consumer to purchase and use the product.

The main limitation with branded advertising is that it is difficult to convey potentially negative messages. With a brand image that is centered on "being cool" and "enjoying life," for example, it would not be possible to include messages that suggest: "You might be at risk for HIV…" without seriously damaging your brand image and equity.

In order to deal with these and other negative (or complicated) messages, PSI will develop generic communications campaigns that do not make reference to the branded product.



PSI Behavior Change Model

The Social Marketing Behavior Change Model

PSI has developed a behavior change model (figure x) that incorporates leading theoretical constructs into a framework combining key concepts from the fields of behavioral sciences and marketing. The behavior change model can be applied to different target groups yielding different strategies or messages to emphasize, depending on the characteristics of each target group.

These terms can be defined in simple sentences describing an individual's perceptions:

Awareness of Disease: "I have heard of HIV/AIDS. It is a disease that affects humans. HIV/AIDS is present in my country."

Understanding Transmission: "I know how HIV/AIDS is passed on. HIV/AIDS is primarily transmitted through sexual relations."

Appreciating Severity: "I believe that HIV/AIDS kills. I do not believe that there is a cure."

Personal Risk Perception: "I am at risk of catching HIV/AIDS. My behavior puts me at risk. Sexual relations with people I think are healthy looking can put me at risk."

Solution Efficacy: "Condoms are effective in preventing transmission. Condoms don't break if used properly."

Self-Efficacy: "I believe that I have the ability to take action. I can use a condom correctly. I can negotiate condom use with my partner."

Brand Appeal: "I see the image of the brand as positive. It is a quality brand."

Accessibility: " I know I can find condoms when I need them. Condoms are easy to find day or night."

Affordability: "I can afford to buy condoms on a regular basis."

Social Support: "People whose opinion I value will support my use of condoms. It is normal for people like me to use condoms. My peers and parents approve of using condoms."

The model illustrates how variables such as knowledge of a disease and an appreciation of its severity contribute to an individual's sense of personal risk or susceptibility to the disease. Knowledge of how the disease is transmitted also contributes to perceptions of how a product's attributes represent a solution, in this case, condoms as a means of prevention.

Another influential variable in behavior change is self-efficacy, which is the belief that one can perform a certain behavior. Self-efficacy plays an important role in HIV/AIDS prevention since an individual must act in ways that may go against cultural norms. For instance, a woman can know about HIV/AIDS, and she may know that condoms are effective in preventing transmission of the disease. She may also feel at risk because she knows her boyfriend or husband has another partner. Nonetheless, if she feels unable to discuss condom use with her husband, then it is unlikely that she will be able to protect herself from possibly becoming infected with HIV from her boyfriend or husband.

It is also important to create an enabling environment by creating brand appeal and by increasing product availability and affordability. Product availability in a range of outlets during all times of day and night at an affordable price reduces physical barriers to purchasing a condom that could discourage behavior change.

Finally, it is critical that the individual's social environment supports choices and dialogue. This social environment includes law and policy makers (for example, allowing mass media advertising and restrictions on sales outlets), credible spokespersons (such as politicians and religious leaders), influential people on a community level (such as teachers), and families and parents.

Appendix iv. Contact List

A. KAZAKHSTAN

Organization	Name of Persons	Contact information
Abt Associates	Roman Polachansky Reproductive Health Specialist Malika Baiserke Public Health Specialist	39 Begalina Street 480100 Almaty, Kazakhstan Tel: (3272) 915775, 919433 Fax: (3272) 919409 Email: rpolachansky@zreform.almaty.kz malika@zreform.almaty.kz
AC Nielsen	Madina Ayupova Senior Client Sales Executive Retail Measurement Service Madina Makatova Client Sales Executive	65 Kazbek Bi Street, Office 704 480091 Almaty, Kazakhstan Tel: (3272) 624720, 635660 Fax: (3272) 503931 Email: Madina.Ayupova@nursat.kz Madina.Makatova@nursat.kz Website: http://acnielsen.com
Academy for Educational Development (AED)	Dinara Adil Participant Training Manager Serik Abdildinov Program Specialist	81 Abylai Khan Avenue, Suite 315 480091 Almaty, Kazakhstan Tel: (3272) 626761, 629087 Fax: (3272) 588547 Email: aed-car@kaznet.kz
Almaty Oblast AIDS Centre	Dr Murat Saparbekov Director	34 Makataev Street 480002 Almaty, Kazakhstan Tel/Fax: (3272) 300871
City Human Reproductive	Tamara Jussubaliyeva Chief Doctor	124 Jibek Joly Street 480091 Almaty, Kazakhstan

Center		Tel/Fax: (3272) 323343 Email: person@itte.kz
Farmaktiv	Fernand Zoghbi General Manager	154 Tulebaeva Street, Office 1 Almaty, Kazakhstan Tel: (3272) 625271 Fax: (3272) 695652 Mobile: (7) 3003 147172 Email: farmaktiv@nursat.kz
Innotech	Pavel Deryabin Country Representative	60 Raimbeka Street 480002 Almaty, Kazakhstan Tel/Fax: (3272) 301639
IPPF	Alfiya Shamsutdinova Program Officer	245 Mukanova Street, Apt 19 480008 Almaty, Kazakhstan Tel/Fax: (3272) 684108 E-mail: ashippf@asdc.kz
McCann Erickson Kazakhstan	Marat Zhanispayev General Manager Saida Buzunova Media Manager	157 Prospect Abaya, Office 12 480009 Almaty, Kazakhstan Tel: (3272) 509386 / 387 Fax: (3272) 509689 Email: MCE@nursat.kz
Ministry of Health Republican Center for AIDS Prevention and Control	Dr Turar Chaklikov	84 Auezov Street 480008 Almaty, Kazakhstan Tel: (3272) 539713 Fax: (3272) 509262 Email: rc@aids.ricc.kz
Schering	Alfia Tushakova Marketing Manager	153 Abay Avenue (Office 19-20) 480009 Almaty, Kazakhstan Tel: (3272) 509396

		Fax: (3272) 509301 Email: alfiatushakova@nursat.kz
TACIS	Brian Toll Head, Technical Assistance	20a Kazibek Bi 480100 Almaty, Kazakhstan Tel: (3272) 636265 Fax: (3272) 910749 Email: Brian.Toll@delkaz.cec.eu.int
UNAIDS	Dr Rudick Adamian UNAIDS Intercountry Program Advisor for CAR	UN Office, 67 Tole Bi Street 480091 Almaty, Kazakhstan Tel: (3272) 627444, 582643 Fax: (3272) 582645, 505907 Email: rudik.adamyan@undp.org
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